FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

MHP FINAL Report

Los Angeles

Conducted on

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INTRODUCTION

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of Managed Care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

- MHP information:
  - Medi-Cal beneficiaries served in CY13— 160,258
  - MHP Size—Extra Large
  - MHP Region—Los Angeles
  - MHP Threshold Languages—Spanish, Vietnamese, Cantonese, English, Mandarin, Other Chinese, Armenian, Russian, Tagalog, Korean, Farsi, Cambodian, Arabic.
  - MHP Location—Los Angeles

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the Los Angeles County Department of Mental Health (LACDMH/DMH) mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

The EQRO process for each LACDMH review cycle involves an intensive focus on two of the eight Service Areas (SAs), as well as an evaluation of systemic priorities, challenges, and initiatives issues, activities and priorities. For FY 2014-2015, the EQRO Report focuses upon SA-8 and SA-7.

SA 8 is called "South Bay," and includes 21 cities such as San Pedro, Long Beach, surrounding communities and Catalina Island. SA-8 enrolled Medi-Cal (MC) beneficiaries include 57.1% Latino, 21.6% African American, 10.1% White, 11.0% Asian/Pacific Islanders, and .17% Native Americans. South Bay's MC non-English languages include Spanish speakers (32.4%) and Cambodian (Khmer) (1.8%).

SA-7 is called "East," and includes 20 cities such as Cerritos, Downey and surrounding communities. SA-7s enrolled Medi-Cal (MC) beneficiaries include 85.4% Latino, 7.0% White, 3.1% African American, 4.3% Asian/Pacific Islanders, and .13% Native Americans.

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark.
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Los Angeles MHP submitted two PIP(s) for validation through the EQRO review. The PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES[3]

Utilizing the Information Systems Capabilities Assessment (ISCA) protocol, the EQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included review of the MHP's reporting systems and methodologies for calculating Performance Measures (PM).

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

The EQRO examined available consumer satisfaction surveys conducted by DHCS, the MHP or its subcontractors.

CalEQRO also conducted four 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

(5) KEY COMPONENTS, SIGNIFICANT CHANGES, ASSESSMENT OF STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT, RECOMMENDATIONS

The CalEQRO review draws upon prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

Ratings for Key Components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY13-14

- Recommendation #1: Working with County Human Resources, re-evaluate how existing Mental Health Advocate qualifications, unintentionally, create barriers to peer employment and possibly advancement. Include input from the EAO, the OFE, Wellness Center peer employees/supervisors, and WOWs.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has considered the substance of this recommendation. There does exist a career ladder of up to four levels for consumer employees, starting with the Wellness Outreach Worker (WOW) volunteer/stipend reimbursed position, to full-time Advocate, Community Worker, and Senior Community Worker positions. The MHP states that only the higher Medical Caseworker position has an educational requirement of a bachelor's degree.
  - The EQRO is aware of the MHP's continued efforts to bring about greater consumer/family member employment, including those additional planned with

SB82 Mobile Triage teams, which should result in an increase of 48 WOW workers.

- The EQRO recommends the MHP continue its efforts to broaden the consumer/family career ladder by considering working with Human Resources to modify the minimum qualifications for higher level positions that do not require professional training and licensure by the substitution of years of successful employment at lower levels as qualifying experience in lieu of advanced education on a year by year basis.

- Recommendation #2: Investigate the ability to reimburse contract providers for SD/MC services to prevent delays in provider monthly revenue flow during the LE IBHIS claims go-live process. Communicate with providers to ensure they are fully aware of what they need to complete for timely reimbursement during the process.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- As related to the Integrated Behavioral Health Information System (IBHIS) implementation, the MHP changed its payment process to reimburse providers based on submitted, not adjudicated, claims. Claims are paid upon submission to the department. In addition, due to system errors that created duplicate 837s, for FY 14-15 the contract period organizational provider contracts were modified to permit advance payments when claims submissions were blocked due to an issue preventing denied claims from being reworked.

- Recommendation #3: Within the QID and departmental QIC, develop clear guidelines/expectations regarding consistent Service Area quality indicator/data review and use and SA-specific routine QI efforts and improvement projects. Consider creating a standardized system-wide QIC minutes format to demonstrate such activities occur routinely, as expected.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The Quality Improvement Policy 105.1 was revised to include guidelines for creating a consistent and standardized system-wide QIC minutes format similar to the Departmental QIC minutes format. All SA QIC Chairs and Co-Chairs were directed by the Departmental QIC Chair to use the same format as the Departmental QIC minutes and all SA QIC Chairs and Co- Chairs received a sample template of the Departmental QIC minutes. Pre-Review document submissions were reflective of these changes.
- At the Departmental QIC meetings and via QID email communications, clear guidelines were provided regarding consistent SA quality indicator/data review and use.
- The MHP provided examples of consistent indicator review, including change of provider.

- Recommendation #4: Monitor and engage the approximately 30 legal entities that have yet to select or implement a local EHR system. Provide technical assistance and EHR project management guidance, where appropriate.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - During the past 12 months considerable progress has been accomplished with regard to Legal Entity (LE) local EHR implementation. As of February 2015, all LEs that are required to submit clients and claims data to DMH have completed their EHR selection.
  - The substantial progress during the past year was attributed to the following:
    - ▷ LEs and their EHR vendors motivation to achieve IBHIS readiness
    - ▷ Regularly scheduled status update calls with EHR vendors as they developed data exchange capabilities according to DMH specifications
    - ▷ Regularly scheduled status update calls with LEs as they progress through EDI certification process
    - ▷ Creation of generic e-mail accounts specific to three primary areas of IBHIS certification – Provisioning, Web Services, and Claims that enable triage and rapid response to EHR vendor and LE questions
  - As of April 2015, IBHIS overall implementation status reports:
    - ▷ Two LEs have selected IS Vendors who are evaluating IBHIS requirements to determine if they can meet DMH and customer expectations;
    - ▷ Four LEs have initiated implementation activities but have not yet tested electronic data interchange (EDI) with DMH;
    - ▷ 51 LEs have completed IBHIS EDI certification process and are ready for go-live when DMH resumes LE cutover from IS to IBHIS;
    - ▷ The remaining LEs are engaged in the EDI certification process at a sufficient rate that DMH is confident most are positioned to cutover to IBHIS as they are scheduled.

- Recommendation #5: At the SA-level, with centralized support, assess what capacity challenges are most pressing for children's services. Consider the expansion of tele-psychiatry for children as well as fortifying Specialized Foster Care and Multidisciplinary Assessment Team resources that follow newly-referred children for longer periods than planned prior to linkage.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - LACDMH is considering a change to Multidisciplinary Assessment Team (MAT) to facilitate more prompt linkage to services. DMH plans to identify a Service Area to conduct a test where the assessment will be completed as part of the standard initiation of treatment. The MAT provider would retain the case for

treatment to reduce the wait time for services. Based on test feedback, DMH will consider countywide changes to the MAT program.

- Tele-psychiatry:
  - Tele-psychiatry services have been available and used in Service Area 1 and Service Area 8 for the past few years. Both SA's have unique service delivery challenges: SA-1 is high desert and sparsely populated, and SA-8 serves residents of Catalina Islands. They reported an increase of the number children and youth served and decreased wait times to access services due to tele-psychiatry.
  - Countywide Services Division along with Chief Information Office Bureau (CIOB) and the Office of Medical Director (OMD) are in planning and pilot roll-out phase of tele-psychiatry services for other Service Areas. Among the activities being developed is the provision of tele-psychiatric services for children and youth in specialized Foster Care co-located sites that require emergent assessment and psychopharmacology services.
  - DMH developed policies and parameters to implement tele-psychiatry services. DMH Policy 202.36, defines the use of tele-psychiatry, specifies the equipment, procedures, consent, tele-psychiatric treatment, assessment, psychopharmacology, documentation, and quality improvement. The DMH Office of Medical Director (OMD) developed 2.4 Parameters for the use of tele-psychiatry and tele-mental health service delivery to provide additional clarification regarding general requirements, responsibilities and workflow of staff involved.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality, including those changes that provide context to areas discussed later in this report.

- Access to Care
  - Access to Care Improvement Process: Starting in summer of 2014, the MHP began a process of reviewing all aspects of initial access, including the myriad of entry portals, SA-based and countywide, including those that are internal vs external, and which was focused upon and governed by timeliness to care principles. The process wound down during November of 2014 and late January 2015, following a series of work groups that included contract providers, wherein decisions were made to 1) streamline and reduce the number of external access portals; 2) creation of uniform portal expectations, universal

screening tools, and; 3) staged movement to a centralized, technologically supported access model.

- SB82 Proposed Programs - California Health Facilities Financing Authority
  - Three Urgent Care Centers (UCCs) are slated for creation, in addition to the existing four adult UCC programs, providing short-term, 23-hour crisis intervention services to individuals over the age of 13.
  - 35 new Crisis Residential Treatment Programs are scheduled for creation, serving 12-16 individuals for a period of 10-14 days.
- Mobile Triage Teams: (SB82 Grant) The MHP has obtained $11M to fund mobile triage teams, with an emphasis on hiring individuals with lived experience to fill nearly 50% of the new positions. These teams will include:
  - Youth Crisis Placement Stabilization Team- This will serve individuals under the age of 21 who have been detained by Child and Family Services and are awaiting placement.
  - DMH Mobile Triage Teams -Directly Operated (County DMH) teams will be created in each SA. Positions are currently in the process of being filled.
  - Forensic Outreach Teams – Individuals released from jail are the target of this new team, and will be provided short-term intensive case management to link with services.
  - Crisis Transition Specialist Teams -These teams will engage and support Urgent Care Center (UCC) consumers, providing intensive case management for up to 60 days following a UCC contact.
- Laura's Law/AOT: Los Angeles County has adopted the Assisted Outpatient Treatment (AOT) model or Laura's Law, and is in the process of collaborating with stakeholders to develop a model of service delivery that fits the MHP's environment. The law provides for a legal mandate to be established for individual to accept services where substantial risk for deterioration and/or detention under W&I 5150 is demonstrated. A number of program enhancements will be established to support the AOT evaluation and treatment process, including navigation teams, full service partnership expansion, and alternative crisis services.
- Jail Diversion Program: The MHP and law enforcement are collaborating in the development of a program to divert those with mental health, including substance use disorders, from minor criminal charges to treatment in the community. Various elements of this program improve access to care for these individuals through: Pre-Booking Diversion, Pre-Adjudication Diversion, Alternative Sentencing, and in-custody IMD step-down. Goals of this program include:
  - Increased retention in mental health and other needed services by diversion program participants.

- ▷ Reduction in jail recidivism.
- ▷ Refinement of diversion program models that can be replicated throughout the County's mental health and criminal justice systems.

- Timeliness of Services
  - The MHP's study of access, and related decisions around centralization of access, the use of various tracking systems such as the Service Request Log (SRL), SRTS (Service Request Tracking Log), the Vacancy Adjustment and Notification System (VANS) and the STATS monitoring report and related processes show the promise of improving timeliness of initial access. In addition, these processes help the MHP monitor changes in resource allocation needs and make dynamic shifts
- Quality of Care
  - Health Neighborhoods:
    - ▷ In 2014, the County of Los Angeles incorporated into its Strategic Plan the development of health neighborhoods. This initiative is intended to bring together health, mental health, public health (where they provide direct services), and substance abuse treatment providers to establish and enhance collaborative relationships and promote the integration of whole person care. Participating service providers are linked to an extensive network of governmental and community supports, including but not limited to: County and city agencies, educational institutions, housing services, faith-based groups, vocational supports, advocacy and non-profit organizations, prevention programs and social services.
    - ▷ There are two models that come together to make up a Health Neighborhood, specifically a community change model that is designed to address the social determinants of health with an emphasis on policy and system change; and a service delivery component, designed to bring providers together in a neighborhood to expand access to services, increase coordination of care between providers and contain costs.
    - ▷ Meetings were conducted between June and December 2014 in all eight Service Areas, in which DMH joined with representatives from Department of Public Health, Substance Abuse Prevention and Control and LA Care to discuss the concepts related to health neighborhoods. The initial focus was on development of the service delivery component. Seven geographic areas have been selected as possible pilot regions: Lancaster, Pacoima, El Monte, Boyle Heights, Watts/Willowbrook, Southeast Los Angeles, and Central Long Beach.
  - Innovation 1: The MHP's first Innovation project tested three models of health care integration – mental health, substance use and health. The MHP studied the results of each model with extensive analysis of data from the IMR and MORS. The three models tested included:

- ▷ Integrated Clinic Model (ICM): Integrated service delivery where either behavioral health is co-located in a primary care setting or primary care in co-located at a behavioral health site.
- ▷ Integrated Mobile Health Team (IMHT): This model has one team across behavioral health and primary care that operates in the field, assessing and providing services to homeless individuals with co-morbid mental health and physical health and/or substance use conditions who are highly vulnerable.
- ▷ Integrated Services Management (ISM) Model: This model utilizes integrated behavioral health and primary care service partnerships with an added focus on the use of non-traditional services and activities that are culturally congruent to the cultural populations targeted (Latino, African-African American, Asian Pacific Islander, Native American, Middle Eastern/Eastern European).

o Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ): The LGBTQ UREP subcommittee was established on August 27, 2014, and embarked on their first project, launching a LGBTQ survey. The aim of this survey is to gather data pertaining to mental health clinicians' level of awareness and sensitivity when providing services for the LGTBQ population. The findings of the surveys will be used to assist the subcommittee to better identify future capacity building projects targeted for the LGBTQ community.

- ▷ For FY 14-15, the LGBTQ UREP subcommittee will fund two projects that focus on mental health awareness, mental health education, and to increase access and penetration rates. This includes focusing on development of a culturally competent family advocacy program that will provide peer-to-peer support and family-to-family outreach and education.
- ▷ The second project will provide trainings, technical assistance, and mentoring services to mental health providers as an avenue to increase their knowledge, skills, and ultimately, enhance their clinical skills to better serve the LGBTQ youth population. The approval of these projects is in process.

- Consumer Outcomes
  - o The MHP presented extensive outcomes analysis of all its Innovations programs.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2015.

TOTAL BENEFICIARIES SERVED

Table 1 provides detail on beneficiaries served by race/ethnicity.

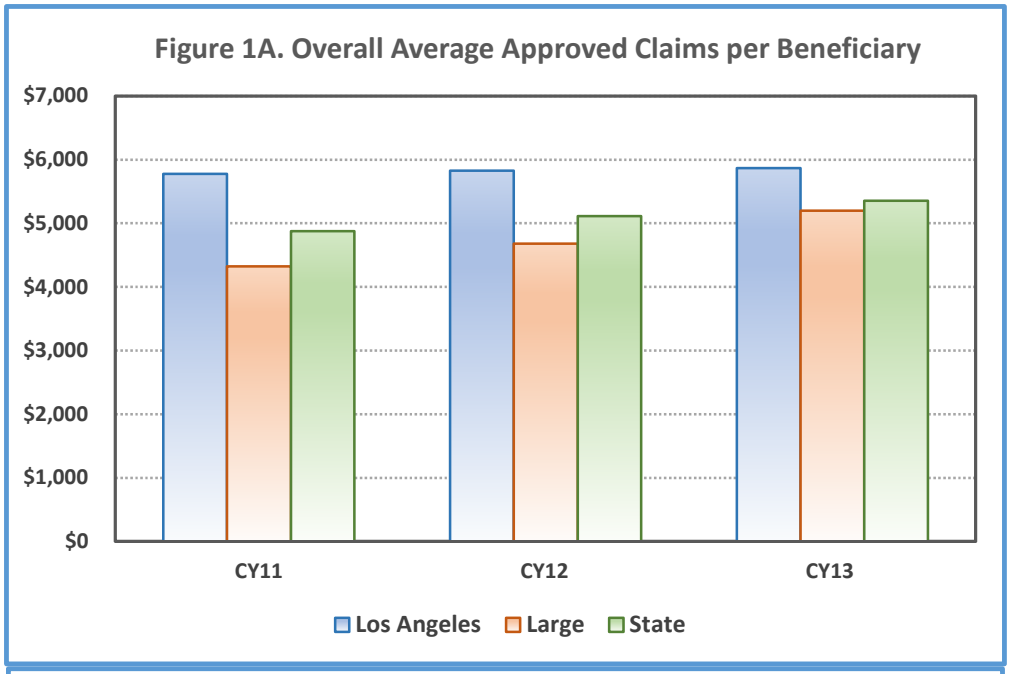
Table 1—Los Angeles MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

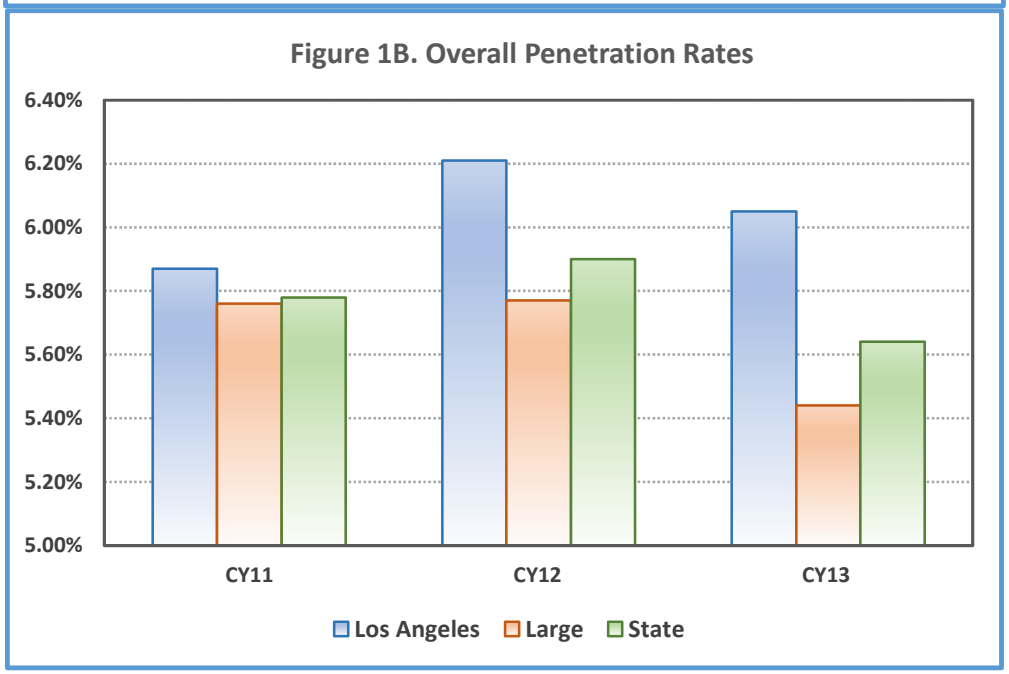
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	293,039	33,183
Hispanic	1,653,762	74,286
African-American	263,594	30,323
Asian/Pacific Islander	207,215	7,788
Native American	2,792	490
Other	229,105	14,188
Total	2,649,505	160,258

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

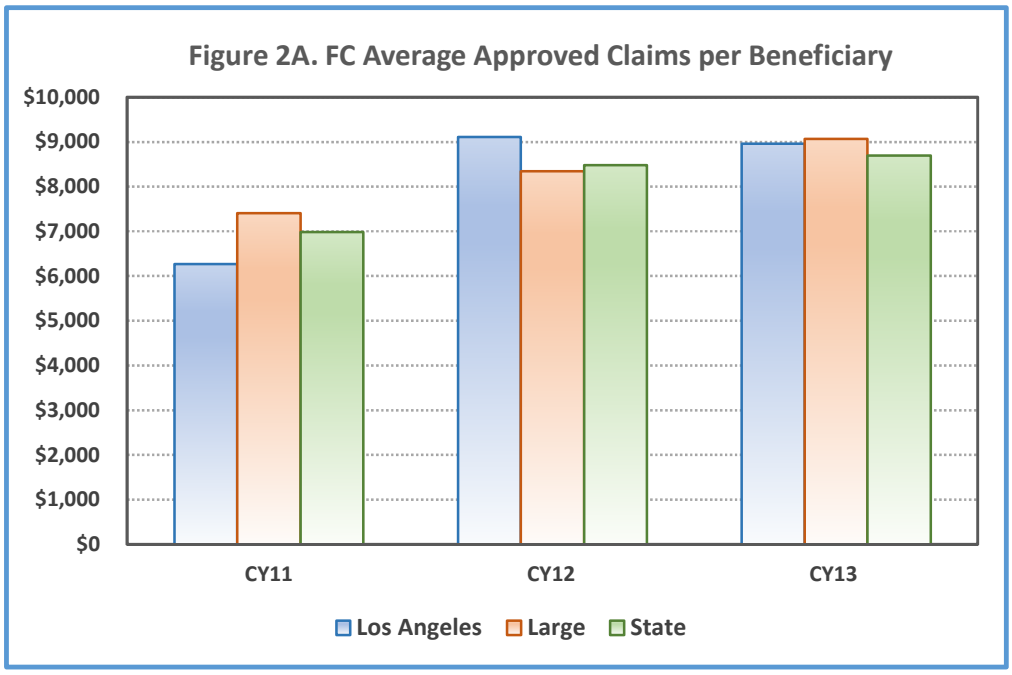
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

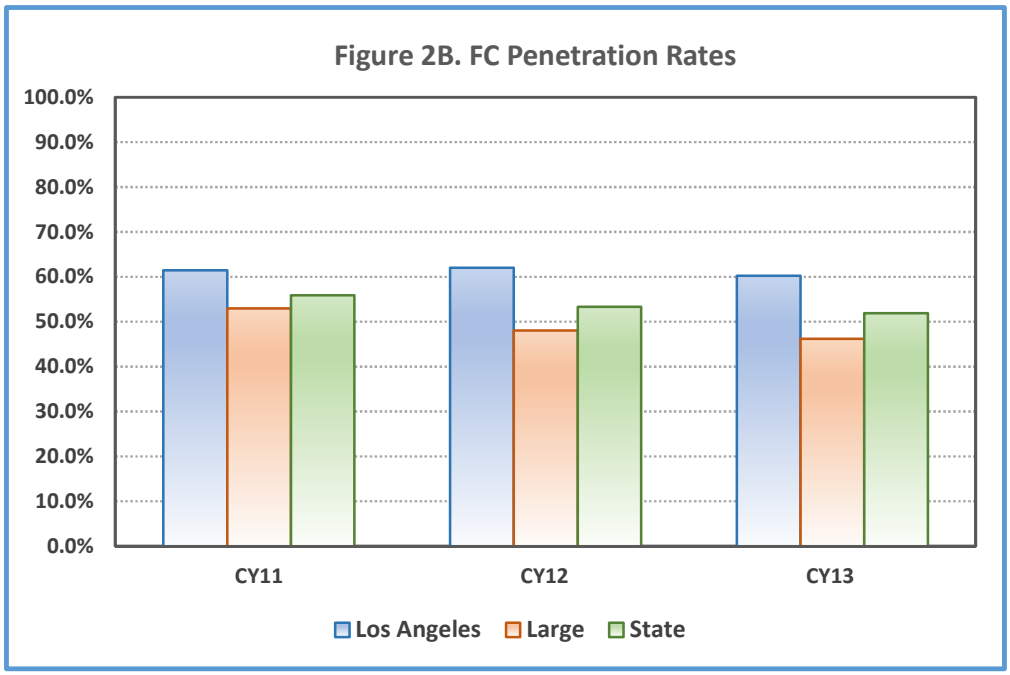
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



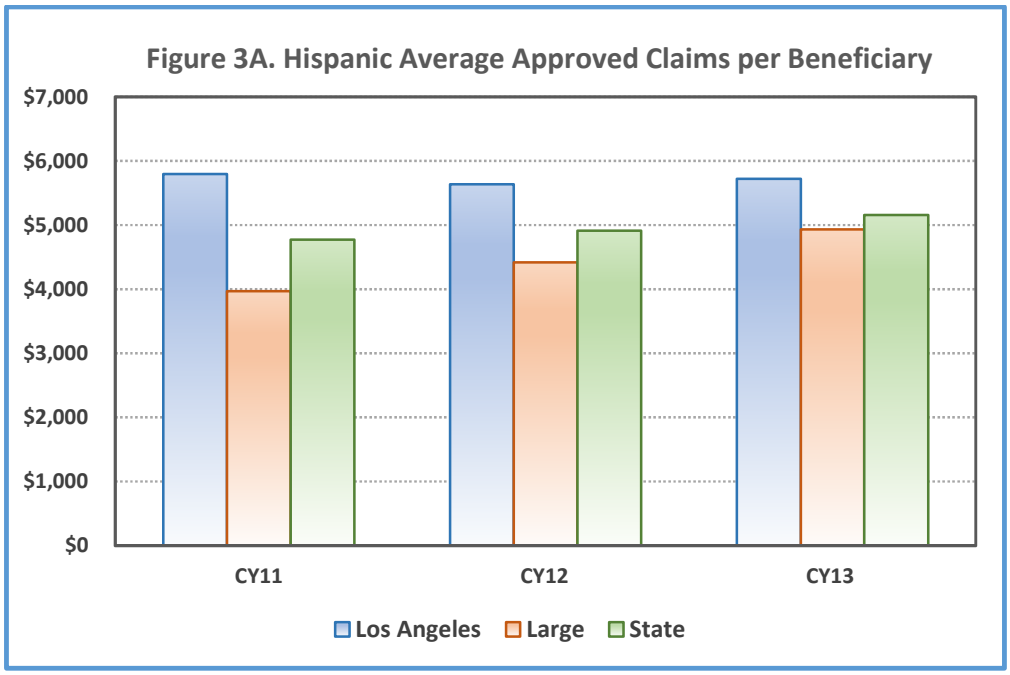


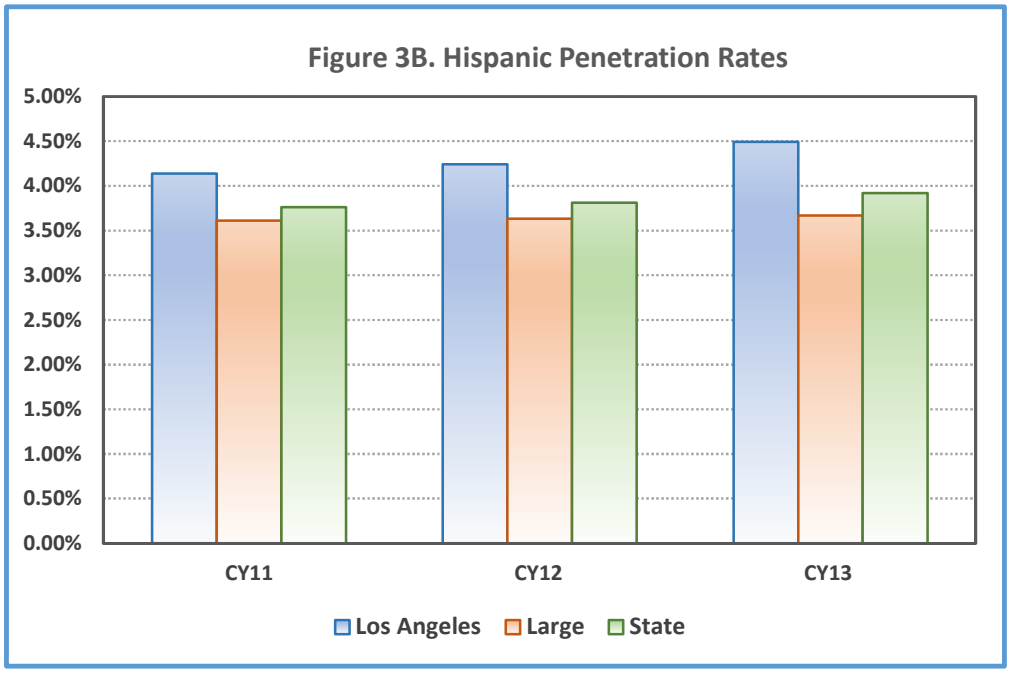
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





Figures 3A and 3B show 3-year trends of the MHP's Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY13 with the MHP's data for CY13, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
Los Angeles	CY13	4,353	160,258	2.72%	$49,104	$213,748,386	22.75%
	CY12	4,444	155,845	2.85%	$50,210	$223,134,187	24.59%
	CY11	4,401	147,433	2.99%	$50,100	$220,490,148	25.91%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

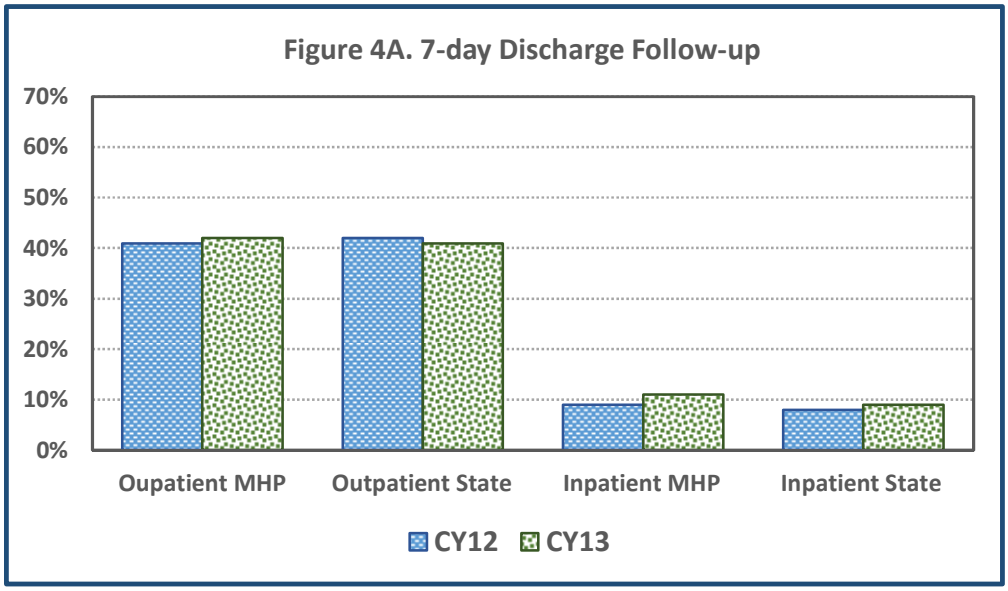
Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

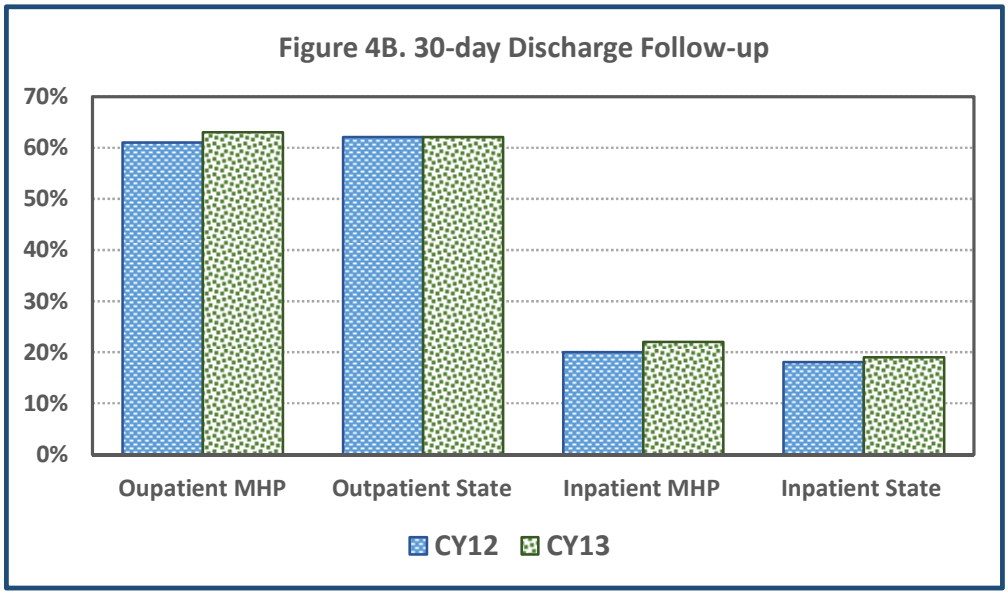
Table 3—TBS Beneficiary Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Beneficiaries Served by MHP	TBS Beneficiary Count	TBS Penetration Rate
Los Angeles	Yes	86,136	2,329	2.70%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

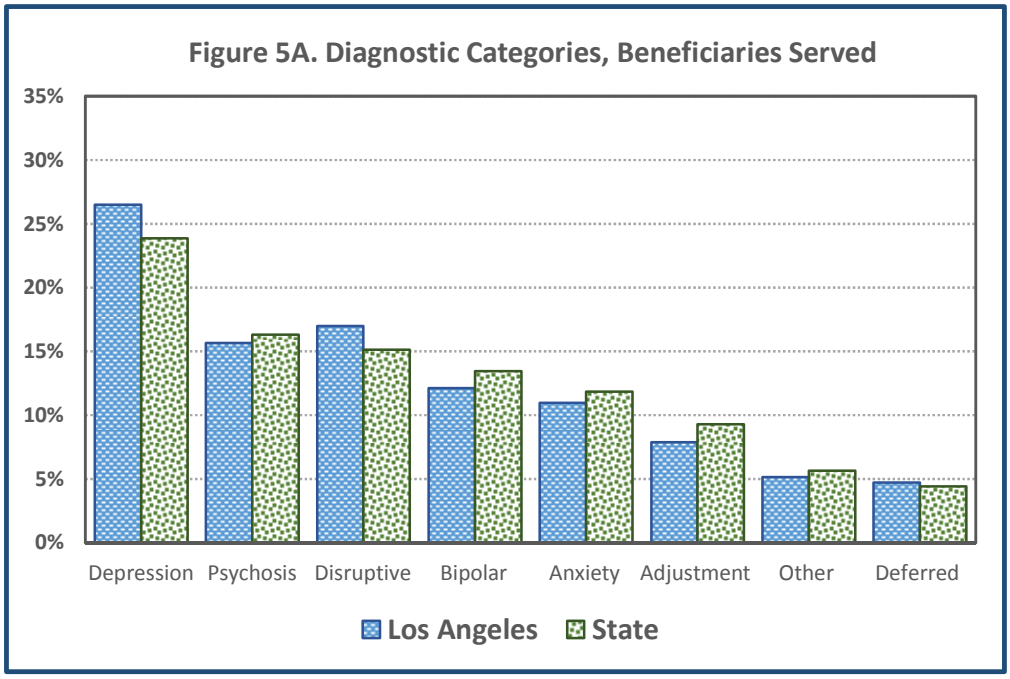
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

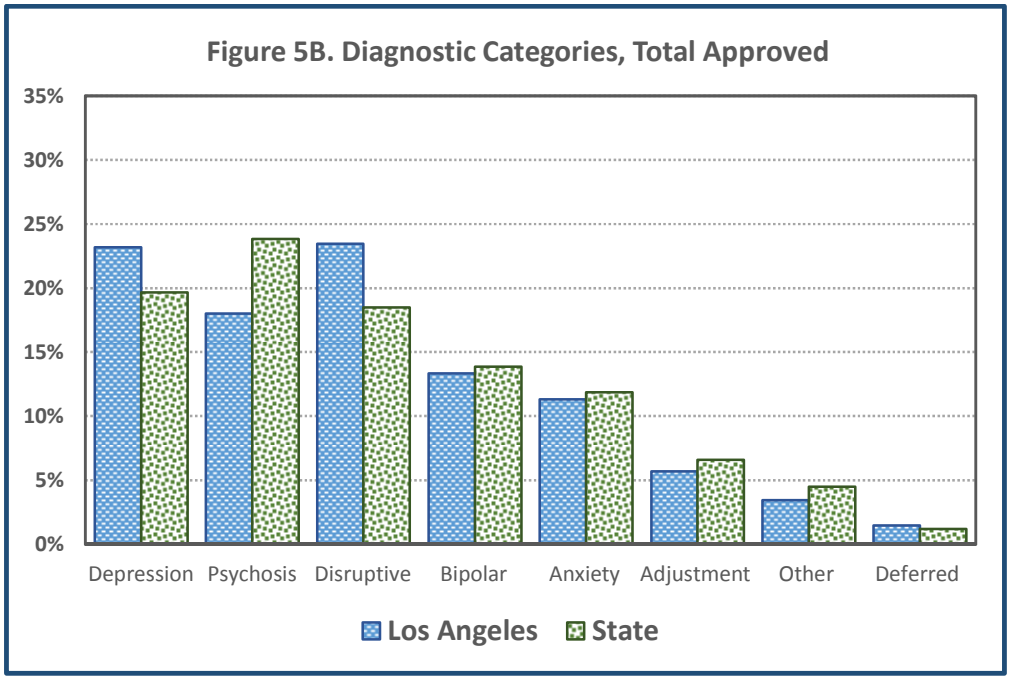




DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY13.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate is significantly higher than both the large MHP average and statewide average overall penetration rates; however, it has moderately declined since CY12.
  - The MHP's foster care penetration rate is moderately higher than both the large MHP average and statewide average foster care penetration rates.
  - The MHP's Hispanic penetration rate is significantly higher than the large MHP average and moderately higher than the statewide average Hispanic penetration rates. The MHP's Hispanic penetration rate has increased moderately since CY12.
  - The MHP's TBS Level II penetration rate is moderately lower than the statewide TBS Level II penetration rate.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after psychiatric inpatient discharge are very similar to the statewide rate.
  - The MHP's 7 and 30 day inpatient recidivism rates are similar to the statewide rate.
- Quality of Care
  - The MHP's percentage of high-cost beneficiaries is slightly lower than statewide; the MHP's corresponding percentage of total approved claims is significantly lower than statewide.
  - The MHP's overall and Hispanic average approved claims per beneficiary are moderately higher than corresponding averages for large MHPs and statewide. The MHP's foster care average approved claims per beneficiary are similar to both large MHPs and statewide.
  - The MHP's distribution of diagnostic categories is very similar to the statewide distribution. The MHP has a slightly higher incidence of depression and disruptive diagnoses than statewide. The MHP has very similar incidences of other and deferred diagnosis categories to statewide and correspondingly low total approved claims in comparison to statewide figures.
- Consumer Outcomes
  - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care … that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2013.

LOS ANGELES MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Los Angeles MHP submitted two PIP(s) for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	Commercial Sexual Exploitation of Children (CSEC). Onsite technical assistance was provided to identify future PIP topics.
Non-Clinical PIP	Vacancy Adjustment and Notification System (VANS). Onsite technical assistance was provided to identify future PIP topics.

Table 4A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	PM
		1.3	Broad spectrum of key aspects of enrollee care and services	M	PM
		1.4	All enrolled populations	M	PM
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	PM	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	PM
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	PM	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	PM	M
		6.4	Plan for consistent and accurate data collection	PM	PM
		6.5	Prospective data analysis plan including contingencies	PM	PM
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NA	PM
		7.2	Interim data triggering modifications as needed	NA	PM
		7.3	Data presented in adherence to the plan	NA	PM
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NA	PM
		7.5	Interpretation of results and follow-up	NA	PM

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NA	PM
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	PM
		8.3	Threats to comparability, internal and external validity	NA	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	PM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	PM
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	PM
		9.3	Improvement in performance linked to the PIP	NA	PM
		9.4	Statistical evidence of true improvement	NA	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NM

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	10	9
Number Partially Met	5	18
Number Not Met	0	3
Number Applicable	15	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	83%	60%

CLINICAL PIP— COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CSEC)

The MHP presented its study question for the clinical PIP as follows:

- "Will the CSEC training result in improved clinical outcomes for sampled CSEC victims receiving treatment from clinicians who completed the CSEC training compared to sampled CSEC victims treated previously by these clinicians prior to completing the CSEC training, as measured by: the UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) and the Outcome Questionnaire (OQ)? Will the CSEC training lead to increased clinician confidence regarding ability to effectively identify and treat CSEC victims, as measured by the pre and post CSEC training surveys?"
- Date PIP began: July 1, 2014
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

This Clinical PIP is focused on the population of commercially sexually exploited children (CSEC). According to FBI statistics, three of the largest child prostitution trafficking areas are located within California. During the past two years 1,277 CSEC victims have been identified in the state of California. Available information indicates that accurate identification of these individuals is challenging for a number of reasons – not the least is the reluctance for these individuals to self-identify.

Due to local concerns, in 2013 local members of the Los Angeles Board of Supervisors introduced a resolution to create a countywide, multi-agency response to sexual trafficking of minors. The belief is that the number of individuals victimized by sex trafficking is quite high and therefore a combination of legal, social services and mental health interventions are required. An element of this includes a Succeeding Through Achievement and Resilience (STAR) court for addressing these individuals' needs and helping them resume a more successful lifestyle.

As a clinical matter, the MHP cites studies, one which indicates 68% of CSEC victims suffer from PTSD; another study indicated 35% engaged in self-injurious behavior. Equally concerning was the finding that 25% remained aligned with their pimps, and felt these individuals cared about their welfare. Unplanned pregnancies and significant drug abuse were additional risk factors.

The MHP identifies 17,921 consumers under the age of 21 years who received trauma-focused evidence-based practices during FY13-14. The clinicians who were involved in this care were provided additional training regarding the identification and treatment of CSEC victims. Based on pre/post surveys, the MHP estimates that as many as 750 CSEC victims have been treated by MHP clinicians per year. The number is expected to increase as the results of training are seen in clinical assessments.

The MHP's interventions include training of staff who are already involved in providing trauma-focused EBPs with CSEC specific information. The intended outcome is to increase their awareness of CSEC and related mental health issues, including both treatment issues and strategies to improve CSEC identification in clinical interviews. Additionally, the focus of this training includes a survey to determine improved clinician confidence in treatment of this population.

The strongest clinical indicator proposed in this PIP is the comparison of clinical outcome instruments pre/post training, which involves the use of the PTSD-RI, and YOQ, or OQ, depending upon consumer age.

At the time of this review the MHP was limited to baseline data on clinician survey of CSEC information and confidence.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of discussion of the focus of this PIP, and encouragement of the MHP to emphasize direct clinical results as reflected by the PTSD-RI, as well as the other outcome instruments, and numbers of CSEC consumers served in its data tracking and reporting.

NON-CLINICAL PIP—VACANCY ADJUSTMENT AND NOTIFICATION SYSTEM (VANS)

The MHP presented its study question for the non-clinical PIP as follows:

- "Will the continued implementation of VANS increase the number of referrals to consumers by providers using VANS in SA 4 and SA 5 and thereby improve access to care? Will updates of slot information by funding source such as for Medi-Cal versus Indigent by providers using VANS increase referrals to consumers and thereby increase access to care for the indigent population in these SAs? Will the updates of slot information by language capacity by providers using VANS increase referrals and thereby improve access to care for Non-English speaking consumers in SA 4 and SA 5?"
- Date PIP began: July, 2013
- Status of PIP:

  ☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ No PIP submitted

This PIP's origins are with the Service Area 4, a small but densely populated MHP region including Hollywood, and the City of Los Angeles. Challenges in filling open treatment slots existed for some providers; for others there was not a reliable way of knowing where unused capacity existed when the provider had requests for services it was currently unable to meet. In some instances, this related to needs for Evidence-Based Practices (EBPs); in other cases it relates to specific linguistic capacity or geographic proximity of services.

Following efforts to survey providers and identify the needed elements, VANS was an electronic tracking system that was created. Starting with four of the 75 providers expressing interest in the use of VANS, it increased to 24 providers by February of 2015. Using VANS 31 documented referrals have been made by five providers. It is not known how many times VANS was used in a manner that did not support tracking. In March of 2015, efforts began to bring SA 5 into the VANS user pool.

During the past year, in response to EQRO feedback, the MHP has added a referral button that creates a counting event for VANS referrals. This mechanism has assisted the referral tracking process. A more recent enhancement planned for future implementation includes adding a hyper-link to the referral button which sends an email message to the selected provider.

At the time of this review, the scale of impact has been very small. The expansion of VANS usage among both providers and other SAs will be necessary for the PIP to have a significant impact on consumer access. Equally important will be the ability of the MHP to persuade providers of the benefits of using the VANS system, and perhaps develops enhancements that rewards a LE provider for the use of VANS.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of discussing how the MHP is planning to enhance VANS and improve engagement of providers in its usage.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The VANS Non-Clinical PIP has possibilities of improving access to care, offering a better mechanism for making referrals when individual program's capacity is fully utilized.

  - The CSEC training will provide clinicians with additional skills and strategies used in the assessment of potential sexual trafficking children and youth, which may improve their access to important mental health treatment. An effective engagement process is the first step in helping guide these individuals towards healthier life choices.

- Timeliness of Services
  - The VANS PIP will likely reduce the initial timeliness wait times as well as definitive treatment for those individuals referred to alternate programs using the provider information within this electronic system.
- Quality of Care
  - The CSEC PIP has potential for improving the identification, engagement and treatment of impacted children and youth.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management—an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs—are discussed below.

Access to Care

As shown in Table 5, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 5—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	Los Angeles County DMH engages in extensive study and analysis of issues related to Under-Represented Ethnic Populations (UREP), as well as other aspects of under-representation, and implements interventions to improve services. The MHP completed a related project in March 2015 which targeted LGBTQ, Somali immigrants and the pan-African communities to fund outreach and engagement to these under-served

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			populations. In addition, the MHP did extensive work with American Indian/Alaska Native; Asian Pacific-Islanders; Eastern-European/ Middle-Eastern; and Latino populations. The MHP has also studied the initial access to care, and has made the decision to centralize this process, and is currently in the process of developing an implementation strategy. The MHP tracks and reports out on English vs. Non-English requests for services. The MHP collects specific language and cultural needs at the point of initial system contact. Specific to this current review, SA-7 has directly operated services for Native American Indians (White Bison Group) based on 12 step principles that provide services accessible to native Americans across the county. SA-8 has significant presence of Cambodian individuals, with needs to address those whose are mono-lingual Khmer speakers. Promotores in SA 7 (20) and SA 8 (15) have been established for Hispanic outreach; this type of programming is being considered for other ethnic groups such as African American and Native Americans.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP sets QI Work Plan Goals in the service capacity area. One related metric is the goal to see that at least 50% of estimated Latinos with SED/SMI at or below 138% of Federal Poverty Level will be served by LACDMH. The MHP also has the same type of metric for Asian/Pacific Islanders (APIs). The MHP has met these goals for Latinos and API for CY2014. In area of access to prescribing services, the MHP was able to partially meet its desired 50% increased tele-psychiatry service target by results that reflect 32% increase for CY14. The MHP is in the process of expanding SB82 funded crisis services and is implementing additional urgent care centers, which have been noted to provide improved access. The MHP utilizes many differing and complementary systems to track and monitor capacity, examples including the Outpatient Services Capacity Report, and the recent VANS system that provides information about (non-clinical PIP) unused capacity at contract providers.
1C	Integration and/or collaboration with community based services to improve access	FC	As stated, the MHP has invested in Promotores collaborations to improve access and care for Hispanic/Latino individuals. The MHP is also emphasizing the involvement of Faith-based partners, such as with St. Joseph church in Hawthorne and Lennox. The Faith community has received twelve Clergy Academy classes and training in Emotional CPR, and Mental Health First Aid, among other techniques and approaches to outreach and educate about mental health and provide referrals to the underserved and Spanish-speaking families in these communities. In addition, Long Beach Clergy & Faith Network is held

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			monthly with various partnering faith organizations, clergy members, faith-based social service organizations, and mental health providers. Another example: SA-8 is partnering in the development of Central Long Beach Health Neighborhoods, collaborating with the Multi-Service Center, City of Long Beach Health and Human Services, DPSS, Harbor Interfaith Services, local law enforcement, and the Health Equity Leadership Institute (HELI) workgroup comprised of Cambodian community organizations and leaders. The Long Beach CARE Clinic offers integrated physical and mental health care. This centralization of services has improved access, timeliness, and quality of care of consumers and job satisfaction for team members. All of the MHP's SA 8 directly-operated (DO) adult clinics have implemented elements of the Care Clinic into their operations by minimally having one team member providing Care Clinic to address the consumers' health needs. The MHP has collaboration with UCLA that is focused on Health Reform strategies, and training of MHP staff regarding physical health key issues and priorities. There also exists a collaboration with Harbor UCLA Medical Center on co-occurring physical health conditions, such as diabetes and heart disease. The Health Neighborhood Initiative in SA 7 is bringing together health, mental health, public health, substance abuse providers, hospitals, and representatives of clergy, schools, and consumer groups to deliver integrated care to the poorest 7 cities in SA 7, located in Southeast Los Angeles.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Timeliness of Services

As shown in Table 6, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 6—Timeliness of Services

	Component	Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP has a 21 calendar day standard for initial access/first offered appointment for Directly Operated (DO) clinics. For CY2014, 76.1% of adult consumers seeking access met this standard, and 79.5% of Children/Youth (this reflects data from 105 of the 131 DO programs). Contract providers have a 15 business day standard for initial access/first offered appointments, with and overall average 56%, and currently separate data unavailable for adults and children/youth.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	NC	The MHP does not currently have a process for tracking the time from initial contact to the first psychiatry/prescriber appointment. However, the MHP has created a psychiatry/prescriber services policy, effective 2/2/2015, focused on the scheduling of initial medication services (202.46), which provides extensive detailed directions as how to address a variety of presentations and acuity. This procedure is likely to improve consistent access, particularly for individuals with high-priority presentations.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP reports urgent timeliness data from the Access Center, during business hours, and Psychiatric Mobile Response Team (PMRT) for after hours response. The MHP has a one-hour standard, which is met 82%.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	As a baseline measure of timely access to follow-up after hospital discharge, the MHP reports 59.3% of hospital discharges in FY13-14 received a service from public mental health outpatient program. The MHP has started tracking follow-up appointments following discharge from psychiatric inpatient care for DO programs using data from the Service Request Log (SRL), SRTS and IBHIS. The MHP is also using a system-wide proxy measure for post-hospital follow-up, which looks at outpatient claims occurring within 7 days post hospital discharge and excludes non-face-to-face contacts. The MHP anticipates that with full IBHIS implementation and increased use of SRTS and SRL systems there will be improved quality of post-hospital follow-up data. The MHP's standard for post-hospital follow-up is seven calendar days, for which current data capture indicates 553 total events and an 80.1% success rate in DO programs live on IBHIS for CY2014. A system-wide proxy measure used the same seven-day timeliness standard, but includes a much larger N of 26,415 adults and 6,776 children/youth hospital discharges. Meeting standard is 34.6% for adults and 51% for children and youth.
2E	Tracks and trends data on rehospitalizations	FC	The MHP has a 30-day readmission rate goal of 30% for adults and 16% for children and youth. The actual for adults is 32.3% and for children and youth is 16.9%.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2F	Tracks and trends No Shows	NC	The MHP's tracking of no-shows is currently limited to directly operated programs, and for all services is 9.3%. This data is limited to those DO programs that went live on IBHIS through 2/28/15. The data is based upon 716,864 appointments. Most contracted LEs continue to submit data to IS which does not include no-show information.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Quality of Care

As shown in Table 7, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP utilizes a QI Work Plan that contains numerous measureable performance metrics and has also performed an analysis of the results of the prior work plan. The Quality Improvement Division is staffed with highly qualified individuals, and works to ensure that system quality priorities are monitored and tracked within each SA. There exists a strong communication link between the Director, other leadership members, Service Area District Chiefs and operations, including the Quality Improvement Division (QID). Support of quality improvement process is evident throughout the system. As would be anticipated, in an organization as large as LACDMH occasional challenges exist in the consistency of interpretation and implementation of departmental standards. That said, the department is quick to identify these inconsistencies and takes action to see that correction occurs. An example of this type of improvement activity during the review period relates to data entry for timeliness into SRTS/SRL systems, which resulted in a corrective training. The establishment of a QI email/hotline for anonymous reporting of discrepancies or concerns in the interpretation of policies between Service Areas might help provide QID and leadership with early information for use in course correction and training when this occurs.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3B	Data are used to inform management and guide decisions	FC	The MHP utilizes a multitude of reports to assist in managing services and informing decisions. With the changeover to IBHIS, there have been some delays in information reporting, however the improved capabilities of the new system will soon provide much greater real time information. The Strategies for Total Accountability and Total Success (STATS) report is an impressive compilation of data that is used to support a review of each program that occurs on a structured review cycle. Key staff, including QID and leadership, participate in the review process. This process is utilized to identify issues in capacity, productivity and resource allocation. Review sessions identified that access to the STATS information is reliant upon leadership authorization. The MHP may benefit from creating a minimum authorization list that includes all individuals involved in QI processes that are routinely authorized for STATS access.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3C	Evidence of effective communication from MHP administration	FC	Among the myriad communication efforts of LACDMH, there are many efforts to communicate with consumers and family members. These include: a client advisory board, a newsletter, flyers regarding activities and meetings, and also meetings wherein case workers share information. The MHP has monthly QIC meetings, inclusive of one larger all SA meeting and individual meeting for each SA. These meetings include both leadership and QIC, cultural and linguistic competence staff. SA Advisory Committees provide input to leadership on specific area concerns. These committees are comprised of consumers, family members and staff. Contract organizational providers believe the MHP provides information via multiple channels. The QID, CIOB, and OMD are key elements of the MHP's communication efforts, providing information and training to providers.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	LACDMH possesses a wide array of opportunities for stakeholders to provide input. In addition to the routine meetings that MHP has with stakeholders, there are many specific proactive meetings that target potential changes in operations or others and seek input for newly adopted initiatives, such as the implementation of Laura's Law/AOT. The monthly SA QIC meetings not only are a vehicle for communicating emerging issues and updates, but also provide an opportunity to seek input from stakeholders. In regards to consumer and family input, the Office of Consumer Affairs meets with the Director weekly. In addition, there are coalition meetings, including the Latino Client Coalition, Asian Client Coalition, Black Client Coalition, Los Angeles Client Coalition, the Family Advisory Board and many others.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP has consistently engaged in collaborations with governmental entities, such as law enforcement and the joint mobile response teams, and with Social Services and children's providers as related to foster care services. The recent CSEC PIP features a strong collaboration with the Probation Department and Social Services. In other venues, there exist extensive collaborations with the health department, and non-profits such as Mental Health America and PACS, among others, and regional providers that have a linguistic/cultural focus, such as Asian Pacific Islander Services. For example, In SA 8, Pacific Asian Counseling Services (PACS) implemented the Integrated Network for Cambodians (INC) by promoting collaborative partnerships between formal and non-traditional service providers and community-based organizations to integrate physical health, mental health, and substance abuse for the Cambodian consumers who are primarily monolingual Khmer-speaking population. The MHP has utilized the Clergy Roundtable to engage this important sector of the community, which is of particular importance as the MHP looks at the development of Health Neighborhoods which calls for extensive community and faith collaboration.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP utilizes the internally designed Outcome Measures Application (OMA) to track Full Service Partnership (FSS) and Field Capable Clinical Services (FCCS). This information is regularly published and circulated to contract providers and other stakeholders. The MHP's Prevention and Early Intervention (PEI) Evidence-Based Practice services are each coupled with one or more specific outcome instruments, from which data is routinely reported out. LACDMH has reinvigorated its use of the Milestones of Recovery Scale (MORS) level of care application, seeking to ensure consumer clinical trajectory is regularly evaluated.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP reports monitoring of beneficiary satisfaction for CY2014: The goal of 89% Satisfaction with MHP sensitivity to cultural/ethnic background was met. The goal of 83% consumers and families report overall satisfaction with services was exceeded by the actual of 89%. The MHP's goal of resolving appeals within 45 days and grievances within 60 days was met. The MHP performs extensive analysis of the results of the State DHCS Performance Outcomes Survey MHSIP instrument. The MHP also monitors requests for change of providers at a 94% rate, which was also met. The MHP performed analysis of the state mandated POQI surveys including the MHSIP, YSS, YSS-F, profiling significant findings by age, ethnicity, service area and more. This information is part of a system report that is circulated to MHP and contracted programs. In addition the MHP provided the review team with data from the Child Respite Care Pilot satisfaction survey, a TAY FSP survey, Adult Wellness Center survey, Older Adults FSP Satisfaction survey and Clinic Peer Survey. The Innovations programs compared satisfaction from the different models of care being tested.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP's Office of Consumer and Family Affairs possesses a position within the leadership team, filled by an individual with lived experience. The MHP's WOW positions are expanding significantly with the addition of the SB82 Crisis Outreach workers. The MHP has made strides in consumer/family employment activities, but has also found challenges within the structure of the civil service system and concerns about stigma and the protected status of individuals with disabilities. That said, the MHP does employ many individuals with lived experience directly and through its contractors. This aspect is particularly strong in programs such as Mental Health America programs, such as The Village. Even though making positive strides for a county this large the expectation would be greater number and breadth of consumer/family positions available. Consumer Empowerment has 18 authorized positions, with 50% held by consumer/family members. The career ladder for Peer Employees is: Volunteer, WOW, Ambassador (lobby), MH Peer Advocate, Community Worker, and Senior Community Worker. The MHP might benefit from continuing to explore with Human Resources substitution of successful employment on a year-by-year basis for educational achievement. This has been previously explored with limited success.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	The MHP has extensive Wellness Center programs distributed throughout service areas. In SA-7, the Santa Fe Springs Wellness Center, called FAITH, was visited for this review. This program operates 8am-4:30 pm Monday through Friday. The program's leadership includes an individual with lived experience, and there are two full-time and two part-time staff, peer partners. There is one Mental Health Worker. Approximately 25-30 individuals attend each day. The program is on a bus route, with a stop out front, and a few drive or ride share. Groups include, WRAP, Anger Management, Self Esteem, DBSA, and Coping Wisely. The review team was informed that there are two other Wellness Centers in SA-7. In SA 8, there are seven directly operated Wellness Centers and one contract provider, MHALA.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's activities of studying the diverse access to care system and decisions to consolidate the majority of access functions centrally shows great promise for improving access issues and consistency between Service Areas, which coupled with other service request tracking applications (VANS, SRTS, SRL) will enhance availability of unused capacity.
  - IBHIS has improved DMH's capability to share access to care information between DO clinics. The ability to have knowledge of no-show appointments significantly improves their capability to monitor service delivery capacity.

  - The MHP's efforts to consider all aspects of underserved populations and implement improvement activities span an array of cultures, ethnicities, languages and orientations.

- Timeliness of Services
  - IBHIS has improved DMH's ability to monitor timeliness to services for DO and other providers, and will likely continue to improve as the IBHIS implementation matures and reporting tools are added.
  - The Urgent Care Clinics and the Care Clinic Model offer improved access timeliness to consumers and have the potential side benefit of improving the work experience of staff.
  - The VANS system offers the promise of improved timeliness and utilization of capacity, and has the potential of reducing wait time for services particularly for specialty services, specific linguistic capacity needs, and location.
- Quality of Care
  - The MHP's centralized and SA QI activities function in a complementary fashion.
  - The MHP continuously tracks data that relates to quality of care, and uses this information in ongoing program evaluation in the STATS meetings.
  - The MHP PEI services reflect broad adoption of Evidence Based Practices.
- Consumer Outcomes
  - The MHP continues to extensively analyze and report out data from FSP services, enhanced by the Outcome Measure Application (OMA).
  - The MHP extensively utilizes Evidence-Based Practices in its Prevention and Early Intervention programming, which is associated with data capture through outcome instruments related to the EBPs.
  - The MHP is using the MORS to help make level of service need determinations with its level of care system.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted four 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups, which included the following participant demographics or criteria:

- 8-10 Adult Hispanic/Latino consumers who are have a preferred language of Spanish, and are served by Service Area 8, in the San Pedro/Long Beach area.
- A culturally diverse group of 8-10 adult and TAY consumers, served by Service Area 7, Spanish and English speakers included, initiating services within the past year.
- A culturally diverse group of 8-10 parents/caregivers of children and youth, from the Service Area 8 region, focused on the Cambodian population.
- A multi-cultural parent/caregiver focus group, inclusive of TAY, emphasizing the Hispanic/Latino population drawn from Service Area 7.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This Service Area 8 adult consumer focus group was conducted at the San Pedro Mental Health Center, and was composed of four Hispanic/Latino consumers who were monolingual Spanish speakers. The group was conducted with the help of an interpreter. Focus group participants had received services from one month to six years in duration.

For participants who entered services within the past year, the experience was described as

- A single participant accessed services within the last year, and waited one week for services.
- The service experience of these individuals include:
- The majority of participants receive psychiatry services, often on a monthly basis, with one member only seeing a psychotherapist. Another participant receives meds-only services.
- Very limited feedback was available for crisis/urgent services. There was an example cited of being able to contact the psychiatrist and receive a medication change within a day.

- No difficulties were reported when wanting to change therapists, which is a low frequency event.
- The majority of participants have a primary care physician; these individuals do not know if communication exists between mental health and primary care.
- Practitioners support family involvement with treatment, with one member's husband attending psychiatry sessions with her spouse.
- Wellness Center groups are limited; participants would appreciate a greater focus on stigma-reduction.
- The MHP's communication efforts include: Wellness Center staff sharing information; referrals to services made by therapists; flyers and brochures posted at the Wellness Centers; and church Promotores.
- Psychiatry and psychotherapy visits are conducted at the Wellness Center.

Recommendations arising from this group include:

- Increase the groups conducted in Spanish.
- Increase outreach efforts to engage more participants in Wellness Center groups.
- Provide more English language classes.
- Provide daycare to wellness center participants enabling more single parents to attend.

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1

Category		Number
Total Number of Participants		**4**
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	3 1 0
Ages of Participants	Adult (25–59) Older Adult (60+)	3 1
Preferred Languages	Spanish	4
Race/Ethnicity	Hispanic/Latino	4
Gender	Female	4

Interpreter used for focus group 1: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This Service Area 7 Adult/TAY focus group comprised of nine consumers was conducted at the MHP's Rio Hondo Mental Health Center in Cerritos, California.

For participants who entered services within the past year, the experience was described as

- None of these focus group participants initiated services within the last year.
- The service experiences of these individuals include:
- The frequency of services for these participants varied widely, with four receiving care weekly, others monthly, and one receiving group treatment.
- For urgent treatment needs, a card was provided with the 800 number identified, some therapists provide a direct number for contact, other consumers know to call the clinic.
- The cultural and individual needs of participants are respected. Families are included if requested or desired.
- A number of participants felt that front desk staff lacked understanding of mental illness and compassion. At times they were perceived as rude. That said, those that had brought this issue forward, formally, had seen it addressed and resolved.

Recommendations arising from this group include:

- Focus group participants did not identify common recommendations, resulting in individual recommendations.
- Let staff know they have made a difference in the life of consumers.
- Re-evaluate the compensation paid to peer employees, many of whom receive a $10 stipend.
- Provide more home visits to assess how consumers are actually functioning at home.
- Law enforcement needs to receive more training in working with the mentally ill.
- At some locations, staff need greater sensitivity and customer service training.

Table 8B displays demographic information for the participants in group 2:

Table 8B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants		**9**
Number/Type of Participants	Consumer Only Consumer and Family Member	6 3
Ages of Participants	Young Adult (18-24) Adult (25–59) Older Adult (60+)	1 7 1
Preferred Languages	English Spanish	5 4
Race/Ethnicity	African/American Native American Hispanic/Latino Other	1 1 6 1
Gender	Male Female	6 3

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

This Service Area 8 focus group was conducted at ChildNet Behavioral Health Services in Long Beach California, and included a culturally diverse membership of six Cambodian parents and caregivers of children and youth.

Although children and youth were the focus of this group, some participants represented TAY and adults in treatment, and also children with significant development disability issues.

Focus group leaders felt that some of the concepts and lines of inquiry presented challenges when involving individuals with significant cultural differences, particularly with requesting that participants evaluate the quality of care received from professionals.

The service experience of these individuals include:

- Services are received biweekly in one individual's case, which does not seem adequate to the caregiver, but is all the time that the parent's work schedule allows.

- One participant felt that efforts to contact the therapist often result in long delays for the call back.
- Psychiatry services occur with the support of an interpreter, who speaks Khmer and English.

Recommendations arising from this group include:

- Provide a 24-hour hotline with staff who speak Khmer.
- A parent support group would be helpful, targeting the Cambodian family members.

Table 8C displays demographic information for the participants in group 3:

Table 8C—Consumer/Family Member Focus Group 3

Category		Number
Total Number of Participants		**6**
Number/Type of Participants	Consumer and Family Member	6
Ages of Participants	Adult (25–59) Older Adult (60+)	3 3
Preferred Languages	Other (Khmer)	6
Race/Ethnicity	Other (Cambodian)	6
Gender	Male Female	3 3

Interpreter used for focus group 3: ☐ No ☒ Yes Language: Khmer

CONSUMER/FAMILY MEMBER FOCUS GROUP 4

This Service Area 7 Focus Group was conduced at the Pacific Clinics contract organizational provider located in Santa Fe Springs, and included parents/caregivers of Latino/Hispanic beneficiaries. This focus group included 10 participants.

For the four participants who entered services within the past year, the experience was described as:

- For one parent/caregiver, access to services occurred within one month
- Several experienced a two-week wait until services were accessed.

- One was able to immediately access outpatient services after two inpatient hospitalizations within one month occurred for their child.

The service experience of these individuals includes:

- The frequency of services varies widely among these participants, with two receiving psychotherapy three times weekly, seven once weekly. Psychiatry/prescribing services occur monthly for three participants, one is currently seen weekly.
- Crisis/urgent services are available from the psychiatric emergency service through a telephone call. In addition, the assigned therapist or on-call clinician are readily available. Eight participants have their primary therapist's phone number.
- All participants felt understood and valued, receiving services in their preferred language by a bilingual service provider.
- Many understand that communication occurs between the mental health providers and their primary care physicians.
- The only recent changes experienced by these family members/caregivers were in the psychiatrist/prescriber providing care. For some the change in provider occurred suddenly and without warning.
- These individuals learn about changes in the department from fliers, pamphlets and, for the majority, from the therapist.
- One family is seeking outside support for the stepson's substance abuse problem.

Recommendations arising from this group include:

- Provide more information to parents/caregivers about the child's illness.
- Help with transportation, which is costly and complicated.
- Increase the number of TAY groups
- Provide more mental health training for teachers so that they can be more effective working with children/youth who have mental health problems.

Table 8D displays demographic information for the participants in group 4:

Table 8D—Consumer/Family Member Focus Group 4		
Category		Number
Total Number of Participants		**10**
Number/Type of Participants	Consumer Only Consumer and Family Member	1 9
Ages of Participants	Under 18 Young Adult (18-24) Adult (25–59)	3 1 6
Preferred Languages	English Spanish	5 5
Race/Ethnicity	Hispanic/Latino	10
Gender	Male Female	3 7

Interpreter used for focus group 4: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Increase the number of groups conducted in Spanish.
  - Provide day care so that adults with children may access Wellness Center programs more frequently.
  - Transportation is costly and difficult. Consumers would like to see help in obtaining transportation to services.
- Timeliness of Services
  - Initial access timeliness was considered quite reasonable and quick by the majority of consumers.
- Quality of Care
  - Provide more information to the parents of children and youth in treatment regarding the nature of the illness and more time to discuss strategies that the parents may use.
  - Provide more support groups for families/parents/caregivers of those in treatment, particularly in the Cambodian/Khmer speaking communities.

- Provide more home visits so as to obtain more information about the home environment and the extent to which improvement is occurring.
- Improve the customer service of clinic sites, by doing more to gather input and by through the provision of custom care training.
- Some consumers are concerned about changes in psychiatrists that can occur without notice, an event the MHP would be advised to frequently monitor through on-going site-based satisfaction surveys.

INFORMATION SYSTEMS REVIEW

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

KEY ISCA INFORMATION PROVIDED BY THE MHP

The following information is self-reported by the MHP in the ISCA and/or the site review.

Table 9 shows the percentage of services provided by type of service provider:

Table 9—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	21.4%
Contract providers	75.3%
Network providers	3.3%
Total	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☐ More than 1x month ☒ Weekly ☐ More than 1x weekly

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses:

21%

- MHP self-reported average monthly percent of missed appointments:

11.7%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

The following should be noted with regard to the above information:

- DMH acknowledges co-occurring diagnosis data is not accurate and the percentage reported above underrepresents actual occurrence. DMH expects co-occurring diagnosis data to improve with the ongoing use of IBHIS.
- DMH is now able to track missed appointments through Integrated Behavioral Health Information System (IBHIS) for directly-operated clinics.
- DMH uses Medi-Cal penetration rates to measure served and underserved populations. Penetration rate is produced and used to gauge effectiveness of access/engagement efforts.
- DMH also uses prevalence data to measure poverty levels countywide and is used for program design and resource allocation.

CURRENT OPERATIONS

- IBHIS is a large project with an implementation timeline spanning multiple fiscal years and impacting all phases of DMH operations. DMH developed strategies and work flow processes that simultaneously supports both IS and IBHIS for directly-operated programs, Legal Entity (LE) contract providers, and Fee-for-Service (FFS) providers. The following provides a high-level summary of IS and IBHIS claims flow activities for FY14-15.
- IS has been operational for the past 10 years that supports Practice Management functions and SD/MC Billing system. It is the legacy system, being replaced by IBHIS. As of May 2015, IS continue to support about 120 LE's and all FFS providers.
  - During FY14-15 directly-operated programs transitioned from IS to IBHIS.
  - Many FFS providers manually enter claims into the IS. This is done either by the FFS provider or by their billing agent. Some FFS providers do submit their claims via EDI transactions.
  - LE's are required to enter practice management (client demographic) data along with episodic (client clinical) data into IS. Monthly or more frequently, LE's submit secure files of claim/services. If errors are detected, the file is returned to the LE for correction and reprocessing before claim/services are posted to IS. LE's can also manually key their claims into the IS.
  - IS continues to produce SD/MC claim files which are submitted to the State for adjudication.
- IBHIS is the new system that supports EHR functionality and SD/MC Billing System.

  - During FY14-15 directly-operated programs who support SD/MC and four LE's transitioned from IS to IBHIS.
  - The four LE's now use EDI transactions to exchange secure file transfers between their local systems and IBHIS. EDI provides for two-way exchange of data - from LE to DMH or from DMH to LE. EDI transactions do not flow directly into IBHIS they undergo a "field level" validation before transactions are added or updated.
  - IBHIS produces SD/MC claim files which are submitted to the State for adjudication.
- With IBHIS project implementation and rollout going slower than anticipated the Final System Acceptance will now likely occur during 2015. The original system acceptance date was December 31, 2014.
- DMH also extended the IS Agreement with Sierra Systems for continued support.
- DMH continues to use tele-psychiatry and tele-mental health network to serve Service Area 1 and Service Area 8 clients. The original target population was limited to adults; however that was expanded during FY14-15 to include mobility challenged older adults and children and youth ages 5-17. Thirty-three (33) different languages are supported by the network psychiatrists. During FY13-14 they served 600 adults, and 10 children and youth.
- A contract provider, Didi Hirsch, also provides tele-psychiatry services. During FY14-15 they served 75 clients.

MAJOR CHANGES SINCE LAST YEAR

- The IBHIS project remains a multi-year activity with a number of sub-projects. The following lists critical initiatives that were completed or began in the past year:
  - Deployed IBHIS to approximately 110 directly-operated sites.
  - Upgraded County Network bandwidth at several DMH sites to improve IBHIS performance. Requests to upgrade other sites are pending.
  - Deployed about 650 PC's and/or laptops to support IBHIS rollout.
  - Deployed over 600 MFD/printers as part of Managed Print Services.
  - Implemented OrderConnect application – ePrescribing and Lab transactions.
  - Scan of client paper Medical Records into IBHIS for directly-operated sites implemented.
  - Four LE's successfully cutover from IS to IBHIS

  - Continued to refine Web Services to improve the quality of Client data coming into IBHIS from Trading Partners respective EHR systems.
  - Implemented Practitioner Registration Maintenance (PRM) application.
  - Implemented Service Request Tracking System (SRTS) application.
  - Implement IBHIS Data Integration and Provisioning for LE's and Fee for Services network providers.
  - Published Avatar Security Policy and it received Union approval.
- Contract Provider Technological Needs Project (CPTNP) remains a multi-year initiative. The following lists activities completed during the past year:
  - New LE's initial funding distribution was approved by County Board of Supervisors for IBHIS readiness.
  - For remaining LEs, CPTNP is in "Maintenance/Operational Administration" phase as LE's achieve IBHIS Go-Live readiness.
- Meaningful Use Incentive Program, Phase 1
  - For Program Year 2013, 149 Eligible Professionals were enrolled in Medicaid MU program and DMH received approximately $3.1m incentive funds for FY13-14.
  - For FY2014, 19 additional Eligible Professionals enrolled and DMH received approximately $403k incentive funds for FY14-15.
- Data Warehouse Design Project
  - Re-design DMH data warehouse to include data from IBHIS and MHSA programs which includes new clinical, administrative, and financial data.
  - Prepare data from disparate data sources and to establish appropriate resources to warehouse legacy data.
  - Optimize DMH ability to share and use information within the department, across County departments and processes, and with their non-County business partners in support of Healthcare Reform.
- Data Warehouse Load Project
  - Integrate IBHIS data with IS data into DMH Data Warehouse for reporting purposes and data analyses for Department Program Staff, State Reporting, County Auditors, Contract Providers, and other compliance data requests.
  - Include financial, clinical, and outcomes data and merging of the data for current and future Business Intelligence capabilities.
- Microsoft BizTalk Enterprise Server
  - Develop custom web service interfaces for two-way exchange of data between DMH and LEs (non-county business partners).

  - Support administrative data exchange with over 400 external business partners.
- Tele-Psychiatry Expansion - Enhanced access to care:
  - Serve mobility challenged and/or older adults using video tele-conference (VTC) application to provide mental health services in client homes
  - Serve dually-diagnosed clients using VTC application to provide mental health services to the Department of Public Health Antelope Valley Rehabilitation Center located in Acton, CA.
- DMH is a trusted Certificate Authority that provides a "Public Key" Infrastructure to create and distribute digital certificates to organizations and clinicians that enables a person, computer, or organization to exchange data securely over the Internet.

PRIORITIES FOR THE COMING YEAR

- IBHIS project implementation priorities include:
  - IBHIS contract amendment was developed in early 2015 because of continued dependence of DMH claims processing on supplemental resources from Netsmart Technologies and the need for additional IBHIS modifications to meet DMH requirements. One of the goals is to produce a high-volume of "clean claims" both timely and efficiently.
  - Provide IBHIS roll-out support and technical assistance to LE's that have successfully completed "IBHIS Go-Live Readiness" workflow and their cutover from IS to IBHIS when its determined Avatar can support timely "clean claims" processing.
  - Provide ongoing technical assistance to LE's and IS vendors who have not yet achieved "IBHIS Go-Live Readiness" status.
  - Produce enhancements to PRM application to interface with Netsmart Technologies Avatar Practitioner Web Services.
  - Provide site readiness and roll-out support to implement IBHIS for remaining DMH directly-operated sites that do not provide Medi-Cal billable services.
  - Provide support for eConsult Expansion and Integration with IBHIS.
- Continue work activities to support DMH Data Warehouse Re-design and Load:
  - Exchange of information that supports co-located sites and health Neighborhoods
  - Outcomes data
  - Los Angeles Network for Enhanced Services (LANES)
  - DMH Enterprise Master Person Index (EMPI).
- Support ICD-10 and/or DMS-5 implementation.

- Continue support of Hi-Trust Common Security Framework
- Continue to support Meaningful Use Incentive Program, Stage 2 activities
- DMH user's desktop support and improvements:
  - Migration to County Centralized Microsoft Office 365
  - Desktop encryption
- Continue support of Pharmacy Benefit Management Services Integration
- Continue support of Electronic Psychotropic Medication Authorization (ePMA).

OTHER SIGNIFICANT ISSUES

- While the IS Reports Committee provides an excellent forum to share knowledge of data with contract providers there are limits to how many can attend in-person and conference call capability is significantly less beneficial for call-in participants.
- Avatar systems current inability to timely and efficiently process a high-volume of "clean claims" has delayed IBHIS Final System Acceptance.
- Simultaneous support of both IS and IBHIS systems for an extended period of time has impacted CIOB capacity to re-assign staff to other priority technology projects.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 10—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
IBHIS	CalPM, CWS, MSO, Billing, Order Connect	Netsmart Technologies	>1	Vendor IS/ CIOB
Integrated Systems	Practice Management, Billing	Sierra Systems Group	10	Vendor IS/CIOB
DMH Data Warehouse	Data Cubes for Reporting Purposes	Sierra Systems Group	10	CIOB
BizTalk Integration Engine	Data Integration	Microsoft	3	CIOB
ACCESS Center	Call Center Support	Verizon	2	Vendor IS/CIOB
PATS	Pharmacy Adjudication and Tracking System	County ISD	21	County ISD

PLANS FOR INFORMATION SYSTEMS CHANGE

- DMH continues to implement Netsmart Technologies Avatar application that supports EHR functionality for directly-operated clinics through IBHIS. As of April 2015, all directly-operated clinics that provide SD/MC services are live. The remaining directly-operated sites, about 20, are being phased-in and expected to be live by December 2015.
- Legal Entities (contract providers) are required to implement their own EHR systems and use EDI and/or Web Service transactions to exchange data between their local EHR systems and IBHIS.
- As of April 2015, four (4) Legal Entities have successfully cutover from IS to IBHIS. Most of the remaining LE's are in various states of "go-live readiness" but are on hold, pending Netsmart Technologies completing additional IBHIS modifications to meet DMH requirements.
- A few LE's have not yet selected a local EHR system and are either newly authorized to provide SD/MC services, or the LE continues to do Direct Data Entry (DDE) into IS.
- About 50percent of Fee for Services (FFS) claims are still being submitted via DDE into IS and will need to be converted to EDI transactions when they transition to IBHIS.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Avatar	X			
Clinical decision support	Avatar	X			
Document imaging	Avatar		X		
Electronic signature—client	Avatar	X			
Electronic signature—provider	Avatar	X			
Laboratory results (eLab)	OrderConnect	X			
Outcomes	Avatar	X			

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Prescriptions (eRx)	OrderConnect	X			
Progress notes	Avatar	X			
Treatment plans	Avatar	X			
Summary Totals for EHR Functionality		9	1	0	0

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Table 11 scoring is based on EHR implementation at approximately 110 directly-operated clinics that are authorized to provide SD/MC services.
- DMH estimates document imaging backlog is about 80-90 percent complete, as of April 2015.
- LE's are required to implement their own local EHR systems and use EDI transactions to exchange data between their local system and IBHIS.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - IBHIS provides DMH the capability to measure no show appointments for outpatient clinics which improves their ability to more accurately monitor clinics capacity to serve clients.
- Timeliness of Services
  - IBHIS provides DMH the capability to monitor outpatient timeliness to services for directly-operated clinics.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- Attendance in some contractor line staff sessions did not have the requested numbers in attendance.
- Consumer-Family Member focus group had low attendance in one session, and did not contain the individuals with the requested characteristics in another.
- Leadership and other supervisory/management staff are requested to not attend consumer focus groups or line staff sessions during Service Area reviews, which occurred in several instances.

CONCLUSIONS

During the FY14-15 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP continues to initiate strategies modeled on managed care organizational constructs, creating a pivotal position in health care reform which aims to provide seamless linkages for consumers.
  - The creation of a pre-booking diversion program for low-level offenders with mental health and/or substance issues is a significant innovation and forward thinking. Clinic teams linking individuals who agree to treatment in lieu of being charged can circumvent the revolving cycle of arrests.
  - The American Indian Counseling Center (AICC) program and the Promotores are two of the MHP's many culturally relevant programs that improve access to care for individuals who have historically been under-served.
  - The Urgent Care Clinics provide an intense, non-hospital response to consumers who have highly acute symptoms. The expansion of these programs offers consumers greater opportunity to remain in their home community while stabilization of illness occurs.
  - The CARE clinic model provides rapid access to consumers, a multi-disciplinary team in attendance that is capable of addressing physical health issues, prescribing, case management and follow-up. The model has received a CSAC award and is also reportedly considered rewarding by the involved staff, with other locations seeking to adopt this model.
- Opportunities:
  - The programs that operate in high-risk environments do not believe they receive sufficient safety-related field work training and the option of having a two-person response in some instances. Chance encounters can occur with gangs or other potentially dangerous individuals that are more hazardous to those who operate solo in field response.

- Variances in the interpretation of access standards is thought to occur between service areas, variances that when identified tend to be resolved. But the identification of issues is thought to be somewhat inconsistent.

Timeliness of Services

- Strengths:
  - The MHP MHP's improved efforts to use computerized processes (SRL, SRTS, IBHIS, STATS) for tracking and reporting timeliness has produced more reliable data, and improved timeliness.
  - The MHP has demonstrated the ability to meet and beat the standards it has set for initial service access. The STATS reporting system provides a wealth of timeliness and other capacity data regarding service request outcomes.
  - The various MHP electronic systems are producing increasingly accurate tracking of timeliness, resulting in improvements for consumers.
- Opportunities:
  - The MHP is not yet able to track and report timeliness of prescribing/psychiatry services.
  - The MHP lacks a universal solution for obtaining feedback from both staff and consumers regarding times that initial access responsiveness is not considered adequate.

Quality of Care

- Strengths:
  - Care Clinic Model: Provides integrated services to consumers by a team-based model of service delivery, in which each specialty provides services to the consumer often during one visit. The model also integrates peer services as key members of the treatment team who assist with follow-up, engagement and case management tasks.
  - QID has effectively engaged in ensuring SAs use a standardized documentation format for QI activities.
  - Training opportunities exist and which cover multi-faceted topics. Staff participation is encouraged and supported, despite at times capacity limitations.
  - CIOB staff are very knowledgeable and experienced on a wide range of behavioral health care technology issues. Their communication efforts and activities with contract providers to support IBHIS implementation is especially noteworthy.
  - In addition, the CIOB has extensive collaboration activities to support numerous technology projects with other DMH divisions and County departments.

- Opportunities:
  - The planned merger of the MHP with the Public Health Department warrants community input process to ensure stakeholder concerns are addressed.
  - While the format for minute taking at the various SA QIC meetings has become standardized, the agenda format remains individualized and often minimal, potentially missing specific SA contributions to indicator tracking.
  - The circulation of STATS information is reliant upon active authorization process of leadership staff, which can be a barrier for keeping the diverse SA QI staff informed who are intimately involved in all the quality process of the MHP.
  - Trainings are open to broad participation, first come, first serve. There are possible benefits from creating trainings specific to each SA, and open to specific SA participation. This type of programming may result in greater regional collaborations.

Consumer Outcomes

- Strengths:
  - The Outcome Measure Application (OMA) utilized for FSP and the most intensive of programming provides extensive, detailed information regarding consumer outcomes.
  - The MHP has implemented a level of care process based on the MORS, which will help to identify where each consumer stands in the treatment and recovery continuum, and will also provide guidance as to the locus and level of care.
- Opportunities:
  - The MHP has not yet identified a set of outcome instruments or tools that is applied universally to all non-FSP consumers.

RECOMMENDATIONS

- Convene focus groups involving multiple stakeholders for identification of concerns related to the planned department merger; utilize multi-media technology for those who are unable to attend in person.
- Identify a minimum set of individuals who would routinely receive STATS reports, such as all QID central and SA QI staff, not leaving this to the judgement of District Chiefs or other individuals. This process will assure all QI involved individuals at same levels receive the same information about the department's performance tracking efforts.

- The MHP should consider the establishment of a universal timeliness feedback mechanism published at each intake site, which directs all consumers to provide feedback to the MHP on the timeliness and adequacy of service response.
- Continue to work with Human Resources on an evaluation of positions, such as the Medical Caseworker, that may be suitable for the substitution of work experience for educational requirements on a year by year basis.
- Continue to provide technical assistance to those legal entities and IS vendors who have not yet successfully completed IBHIS Go-Live Readiness workflow.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the Los Angeles County MHP On-Site Review Agenda:

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.caleqro.com

Los Angeles MHP EQRO Review FY14-15

(FY 14-15 Review focus SA8/SA7)

Monday - Day 1

Time	Activity- Address: 550 S. Vermont Ave		
9:00– 9:30	**Opening Session** • Introduction to BHC • MHP Team Introductions • Discussion of Review intent and focus *550 S. Vermont Ave., 2nd Floor Conference Room*		
9:30-12:00 noon	**Review of Past Year** • Significant Changes and Key Initiatives • Response to Previous Year's Recommendations • IBHIS Project (summary of past year activities for entire BHC review team) • STATS – Use of data during past year (3 examples from STATS monthly/quarterly reviews) • SLT Discussion of stakeholder input processing *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* *550 S. Vermont Ave., 2nd Floor Conference Room*		
12:00pm – 1:00 pm	BHC Cal-EQRO Working Lunch		
1:00 – 2:30	**Disparities and Performance Measures** Access, Threshold Languages, Engagement, (Timeliness, Outcomes) *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff* *Jovonne Prices* *695 S. Vermont 15th Floor Glass Conference Room* *JP, SSG, RW*	**Consumer Empowerment/ Peer Inclusion** System-wide peer inclusion efforts *695 S. Vermont Ave., 15th Floor Small Conference. Room* MH/DS/LH	**IBHIS Project Team** • Communications • Avatar Security Policy • County-operated • Contract Providers • Exchange EDI Files • LE Extract Data • Training & Support • Order Connect • Document imaging • Provider Connect, CareConnect, My Health Point **Bill U** 695 S. Vermont Ave., Conference Room 713

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ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, RN, MPA, Lead Quality Reviewer
Jovonne Price, LCSW, Quality Reviewer
Lynda Hutchens, LMFT, Quality Reviewer
Bill Ullom, Lead IS Reviewer
Saumitra SenGupta, Ph.D., Executive Director, BHC CalEQRO
William Holcomb, Ph.D., CEO, BHC
Marilyn Hillerman, Consumer-Family Member, Consultant
Deb Strong, Consumer-Family Member, Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

Sites of MHP Review

MHP SITES

LA County Mental Health Headquarters
550 S. Vermont Avenue
Los Angeles, CA, 90020

Los Angeles County Mental Health
695 S. Vermont Avenue
Los Angeles, CA, 90020

San Pedro Mental Health Center
150 West 7th Street,
San Pedro California

Rio Hondo Mental Health Center
17707 Studebaker Road
Cerritos, CA 90703

CONTRACT PROVIDER SITES

Mhala The Village
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456 Elm Avenue,
Long Beach, CA 90802

ChildNet Behavioral Health Services
5150 East Pacific Coast Highway
Long Beach, CA 90804
Pacific Clinics

Pacific Clinics
11721 E. Telegraph Road
Santa Fe Springs, CA 90670

PARTICIPANTS REPRESENTING THE MHP

Name	Position	Agency
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Adele C. Kelso	Program Head	Rio Hondo MHC
Adrina Moreno	IBHIS PM	CIOB/DMH
Adrine Bazikyan	Quality Improvement Clinical Sup	Penny Lane
Alec Reynolds	West PSC	MH America of LA
Alfredo B. Larios	District Chief	DMH-SAIII
Alma Romero	Revenue	Pacific Clinics
Alvin Karanaratna	Rehab Practitioner	CMA
Ana M. Suarez	District Chief	DMH-SA7
Ana Maria Di Sarli	PSWII	Rio Hondo
Anabel Rodriguez	Mental Health PH	DMH
Anahid Assatourian	SA4 QIC Co-Chair	DMH-Admin
Analia Barroso	Clinical Psychologist	SA7 Administration
Angela Wilson	Senior Clinical Manager	Counseling 4 Kids
Angelle Seetal	Clinical Psychologist	DMH
Ann Lee	QI Liaison	DMH-SA8
Ann Suarez	SA7-Admin	DMH
Anna Kosoff	FSP Lead	Star View Community Services
Anna Perne	Training Coordinator	DMH-TAY
Anna Yaralyan	UREP	DMH
Anne Gustafson	Center Director	Star View Community Services
Anthony Alvarado	Program Head	NEMHC
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Aprill Baker	UREP/CCC Member	DMH
Aracely Miron	Therapist	The Whole Child
Ariana Alvarez		D'Veal

Name	Position	Agency
Arlene Espinosa	MHCI	AICC
Arlette Cremer Wong	CPI	DMH-SFC Commerce
Ashlei Lien	Therapist	Shields For Families
Ashley Ortiz	Lead Program Assistant	St. Anne's
Barbara C. Engleman	Program Head	Hollywood MHC
Barbara Paradise	SA1 QIC Co-Chair	DMH
Beatriz Teroy	Director of QA	Bayfront YFS
Belinda Smith	PSWI	AICC-Wellness
Bert Paras		Child & Family Center
Berta Martinez	CW/Health Navigator	LBMHC
Bertrand Levesque	QA-Psychologist	DMH
Beth Briscoe	CDD	DMH
Beverly Johnston	RN Counsellor	CMA
Bruce Wheatley	Co-Chair Cultural Comp Comm	Inner City Industry
Bryan Mershon	Deputy Director	DMH-CSOC
Caesar Moreno	Director Client Services	The Whole Child
Carla Baires		El Centro de Amistad
Carmen M. Vargas	QA Clinician	ENKI
Carmen Rubio	Clinical Administrator	Shield for Families
Carol Eisen	Regional Medical Director	OMD
Cathy Fisher		Family Crisis Center
Cathy Warner	Deputy Director	DMH
Celeste Meza	PSW	SAMHC
Cheryl Jackson		United American Indian Movement
Christina Garcia	PSWI	AICC
Christina Maeder	PIH	DMH CWD
Claudia Villalta	Lead Therapist	Shield For Families
Coral Compagnoni	Intake Coordinator	Para Los Ninos
Courtney Stephens	Director of QA/QI	MHALA
Cristina Nolf	Mental Health Training Coordinator	Children's Bureau
Crystal Cianfrini-Perry	Program Manager	DMH/DHS Collab
Cynthia Baker	Director of Behavioral Health	Family Services
Cynthia Juarez	PSWII	SAMHC – San Antonio MHC
Cynthia Zamora Marinero	CPII	DMH-MAT/SFC

Name	Position	Agency
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David Tavin		Set Up on Second Street
Dawn Vo-Jutabha	Chief Quality Officer	The Guidance Center
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Debbie Innes-Gomberg	District Chief	PSB
Debra Berzon Leitelt	Training/QA/QI Liaison SA1	DMH
Debra Mahoney	Countywide Children's SA Liaison	DMH
Deidra Hope	Senior Community Worker	DMH-Consumer/Family Affairs
Dennis Griffin	LCSW	ASOC
Dennis Murata	Deputy Director	LACDMH-PSB
Diana Perez-Johnson	Supervisor	San Antonio Mental Health Center
Dianitza Medina	Therapist	Alma Family Services
Doneth Jackson		Anne Sippi Clinic
Dora Anderson	Compliance Nurse	Harbor-UCLA DMH
Dora Palacio	MHC, RN	RHMCH
Earleen Parson	UREP	LACDMH-PSB
Edgar Antionio Villa	PSWII	Rio Hondo MHC
Edna Ramos		The Help Group Child and Family Center
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Elizabeth Gildemontes	OMD-Telemental health	DMH
Elizabeth Velasquez	PSW-I	NEMHC
Ella Granston	QID-HPA II	DMH
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Name	Position	Agency
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Estins Ellis	Therapist	Shields For Families
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Heather Jensen	MH Clinical Program Head	LB Child/Adult Programs
Hector B. Reyes	MH Services Coordinator	DMH-OMD
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Irma Castaneda	EOB	DMH
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Jacqueline Atkins	Region VP Programs	Children's Institute, Inc
Jacquelyn Wilcoxen	District Chief	DMH-SA5
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James Spallino	Project Manager	DMH/CIOB
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Janelle Arambula	PSWI	AICC –American Indian Counseling
Jasmynn Smith	Mental Health Clinician	Olive Crest
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Jeffrey Aguilar	Dis.II	DMH/CIOB
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Name	Position	Agency
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Jenny Morey	Administrator	La Casa Mental Health Urgent Care
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Jessica Ahearn	Supervisor	SA7 Administration
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John Travers	Homeless Innovation	MH America of LA
Joseph Hall	Community Worker	DMH-Consumer/Family Affairs
Joshua Ladue		Set Up on Second Street
Joyce Cudanes	Therapist	Enki
Joyce Toledo	Coordinator	HYC
Juan Jose Fermin, Jr.	Integration Services	DMH/CIOB
Juan Moreno		Exodus Recovery
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Julie Levarinpanich	Director of Operations/QA	DMH
Julie Sabado		The Help Group Child and Family Center
Julie Valdez	Program Head	ACCESS Center
Julieta Sabado		THE
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K. Kerry	DMH	
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Kan Thompson	Operations Director	PCS
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Name	Position	Agency
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Khai Nguyen	QI Clinician	Masada Homes
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Kumar Menon	COORD-HPAIII	CGRD
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Lillian Morgan		The Guidance Center
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Lisa Powell	Supervisor	DMH-SA 8 SB 82 Mobile Triage Team
Lisa Wong	District Chief	DMH-SAII
Lise Ruiz	DMH-IMHT	DMH
Llanette Morgan	Peer Specialist	Hacienda of Hope, Project Return Peer Support Network
Lora Potts	Regional Director Intensive Svcs	Children's Institute
Lori de los Santos	FET Regional Supervisor	Children's Institute, Inc
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Lourdes Duran		Foothill Family Services
Lucain Song	MH Clinical Supervisor	DMH
Lucia C. Cota	PSW	SAMHC

Name	Position	Agency
Lucie Hernandez		The Guidance Center
Lupe Ayala	SA7 QIC Co-Chair	DMH
Luz Pelayo	PSWII	RHMHC
Makesha Jones-Chambers	Clinical Psych II	DMH-TAY
Mandi Buzard	Director of OP Services	Bayfront Youth & Family
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Martin Hernandez	MH Training Coord	DMH PRO
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Marvin Southard	Director	LACDMH
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Melanie j. Cain	Program Head	American Indian Counseling Center
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Michael Tredinnick	Access Center	DMH
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Michelle Rittel	SA2 Children's QI/QA Chair	DMH
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Name	Position	Agency
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Moses Adegbola	Chief Research GIS	LACDMH QI Data
Myla Lampkin	LCSW Clinician	DMH
Myles Kang	HPA III	FSB
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Nancy Gallegos	Assistant VP SPA7	Hathaway-Sycamores
Nancy Serna Nava	PSWI	RHMHC
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Nilsa Gallardo	Program Head	Edelman MHC
Niltan Pova		ECAP
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Pamela Inaba	QIC Member	LAC Client Coalition
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Patricia Burton	QA/QI	Shields For Families
Patricia Sanchez	Field Based Coordinator	For The Child
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Paul Garcia	Mental Health Clinical Sup.	Edelman MHC
Philip Yau	Principle App Per	CIOB/DMH
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Presley Becerra	IT Specialist	DMH
R. Washington	District Chief	DMH-OMD
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Racheal Burgess	PISA	DMH/CIOB
Rafael Zaragoza		El Centro Del Pueblo
Rashauna Fair		Personal Involvement Center
Regina Esparaza	Quality Assurance/Biller	CHCADA
Ricardo Mendoza	Chief MH Psychiatrist	DMH-Tele Med
Ridwan D'Vong		Foothill Family Services
Robert Byrd	District Chief	DMH
Robert Greenless	CIO	DMH/CIOB

Name	Position	Agency
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Roderick Shaner	Medical Director	DMH
Romalis Taylor	Chair AAA UREP	African Coaltion
Rosa Maria Kolds	Program Director	FSP Children's EMHS, LTP
Rosa Torres	PSWII	Roybal FMHC
Rowena Docuyanan	Wrap-Around Liaison	DMH-SA8 SFC Admin
Ruby Castro		Prototypes
Ruth Tisochene	Parent Advocate	AdminNov. Team Specialist
Sam Tran		D'Veal
Samin Yoak	Parent & Family Advocates	Pacific Asian Counseling Services
Sandra Chang Ptasinski	Cultural Comp Unit Supervisor	LACDMH
Sandra Diaz	PSW	San Antonio
Sandra Kramer	MHC Program Head	LACDMH Harbor UCLA Mental Health
Sandra Provencial	Welcome Team PSC	MH America of LA
Sandra Rios	Head of Services	Bayfront Youth & Family
Sandra Rivas		Harbor View
Scott Hanada	Project Heart	DMH-ASOC
Scott North		Hillview MHC
Scua Ly	Director of Mental Health	Helpline Luth.
Sharon Baker		Pacific Clinics
Sheila Sarain		Tessie Cleveland Community Services Corp.
Silvia Rowe	Program Head	San Antonio Mental Health Center
Simon Dayan		Tessie Cleveland Community Services
Sirus Mortir		Prototypes
Socorro Gertmenian		Los Angles Child Guidance Clinic
Stephanie Morabe	Asst. Director	MHA Village
Steven Hendrickson	Program Head	Roybal FMHC
Sue Shearer	Senior VP	Pacific Clinics
Suhasini Shah	IBHIS Assoc. PM	DMH/CIOB
Susie Guerra	Administrator	Telecare
Sylvia Guerrero	SA4 Contract Liaison	DMH
Sylvia Liu	Principle Systems Analyst	CIOB/DMH
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Tara Loboda	ACHSA Policy Assistant	ACH SA

Name	Position	Agency
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Tiffany Flood	Program Director	Didi Hirsch – Inglewood
Toia Hicks		The Guidance Center
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Treva Blackwell	Training Coordinator	DMH-Consumer/Family Affairs
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Veronica Quintana	Management Analyst	DMH-OMD
Vianney Vasquez	MH Clinical Sup.	Hollywood MHC
Wanda Duffy	Therapist-MFT	Masada Homes
Wendy Lopez	Contract Liaison	DMH
Will Max	Dir. Clinical Operations	The Whole Child
Wynne Alexander	Program Director	Didi Hirsch – Inglewood
Youngsook Kim-Sasaki	District Chief	DMH
Yvonne Lopez		Alafia Mental Health
Yvonne Lozano	Asst. Administrator	Star View Community Services
Zena Jacobi	Manager, Revenue System	DMH/CIOB

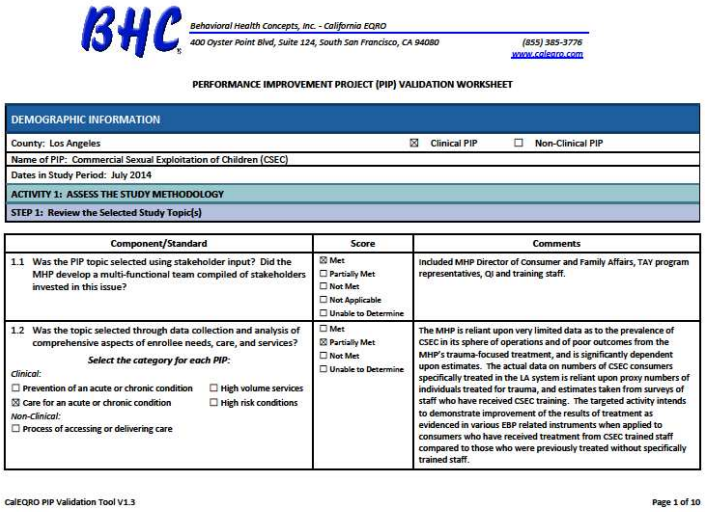
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP separately in a HIPAA-compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Los Angeles	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Commercial Sexual Exploitation of Children (CSEC)		
Dates in Study Period: July 2014		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Included MHP Director of Consumer and Family Affairs, TAY program representatives, QI and training staff.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☐ Process of accessing or delivering care	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is reliant upon very limited data as to the prevalence of CSEC in its sphere of operations and of poor outcomes from the MHP's trauma-focused treatment, and is significantly dependent upon estimates. The actual data on numbers of CSEC consumers specifically treated in the LA system is reliant upon proxy numbers of individuals treated for trauma, and estimates taken from surveys of staff who have received CSEC training. The targeted activity intends to demonstrate improvement of the results of treatment as evidenced in various EBP related instruments when applied to consumers who have received treatment from CSEC trained staff compared to those who were previously treated without specifically trained staff.

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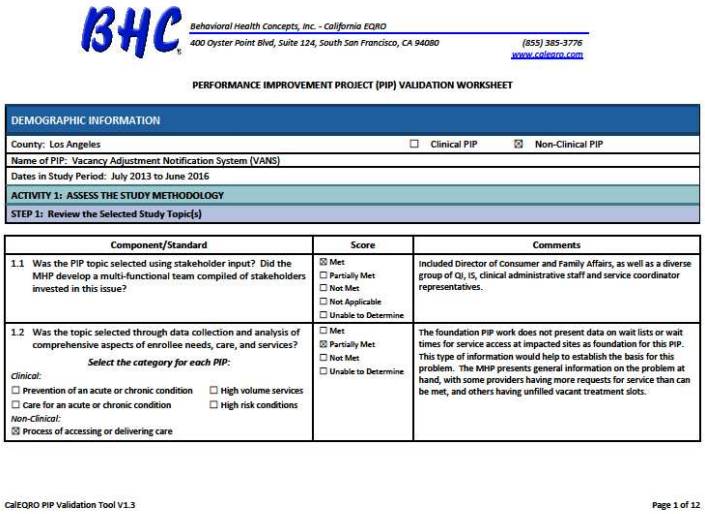
Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Los Angeles	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Vacancy Adjustment Notification System (VANS)		
Dates in Study Period: July 2013 to June 2016		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Included Director of Consumer and Family Affairs, as well as a diverse group of QI, IS, clinical administrative staff and service coordinator representatives.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The foundation PIP work does not present data on wait lists or wait times for service access at impacted sites as foundation for this PIP. This type of information would help to establish the basis for this problem. The MHP presents general information on the problem at hand, with some providers having more requests for service than can be met, and others having unfilled vacant treatment slots.

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